

Using Poetry, Story, and Reflection to Understand Professional Self

After Personal Loss

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Submitted in partial fulfillment

of the requirements for the degree of

Master of Education

Faculty of Education, Brock University

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## **Abstract**

This research investigated professional identity transformation after personal loss. Through autoethnographic methods, I explore how my personal experience of my sister's breast cancer and death affected my identity as a diabetes educator in the health culture. I discover a transformation of a professional who focuses on evidence-based medicine to a professional who values connection, therapeutic alliance, and mindfulness with patients and self in the diabetes education encounter. Using a holistic perspective on transformational learning, I integrate the poem "Wild Geese" to a collection of written narratives to connect my personal loss experience to my professional life. By unpacking the generated stories and using poetry, I conduct a process of critical and self-reflection to discover how my identity as a health professional has transformed and what makes meaning in my role as a diabetes educator in the health culture. I consider concepts of a conscious self, social relations and language and discover themes of knowledge exchange, food, and empathy as forms of language expression. These language expressions are not present in my professional life as I focus on rational, logical facts of evidence-based medicine and standardized education methods. Through this reflexive process, I hope to understand how my professional practice has changed, where I place an importance on connection, therapeutic alliance, and mindfulness. I move away from always "doing" in my professional life to focus on my state of "being" in my professional world. Rather than knowledge acquisition as the only factor in professional development, this study contributes to an understanding of additional qualities health professionals may consider that focus on the patient education encounter.

## Prologue

*I open the box that holds the memories carefully. Somehow if I keep looking at these items, I hope she will be here. Pictures, the memorial program, and old letters we exchanged during our school years when she travelled abroad are all held in this container. There is a book of her favourite poetry also in the box. I come across printed copies of the emails we exchanged during her illness. I printed the emails just in case my computer crashed. What do I do with these emails on the computer? It doesn't seem right to delete them. If I delete them, it is another step in the process to remove her. I need to have them with me. It keeps me close. I want to stay connected with her. What do I do?*

*This is all too painful. Why did this have to happen? It seems so weird that she is gone. Everything we went through together. All of the discussions we had these past 5 years during her illness. I feel the worry and anxiety return as I reread the emails, and I remember us thinking about every possibility that could happen. All of the treatments, the decisions, the medications, the unknowns come back to haunt me.*

*I locate Mary Oliver's (1986) Dream Work and reread a favourite poem of hers, "Wild Geese". I slowly whisper the verse, "you do not have to be good . . . ."*

In the months following my sister's death, I experienced an urgency to remain connected with her. I continuously read the emails we exchanged and recalled memories we shared. The resolution of a very painful experience of her illness and death did not seem imminent. Would this pain and suffering ever resolve? What happened these past five years? What would I do differently if this experience were to

happen again? I began to reflect on the illness experience and how it felt to be a recipient of health care. I began to search for meaning of illness.

### **Acknowledgement/Dedication**

This project would not have been possible without the ongoing support and encouragement from so many people. I wish to acknowledge them all.

To Dr. Hilary Brown, my supervisor, I owe my deepest gratitude for your constant support and invaluable guidance during this project. Your faith in the holistic approach to education taught me to believe in my many ways of knowing, and it pushed me to move forward. I treasure our friendship that we developed during this process. You have expanded my research interests and you have inspired me to trust autoethnography as I consider future research endeavours.

To Dr. Nicola Simmons, thank you for your patience and guidance this past year. I appreciate your wisdom that you provided for this project.

To Chris, my husband, your gentle support and dedication were endless. Thank you for the numerous hours we spent discussing this project over tea. I love you and appreciate all that you do for me.

To Michael and Patrick, my two sons, thank you for your patience and understanding when I was busy with my studies. I am so proud of who you are, and I'm grateful you are both in my life.

Thank you to my Mom and Dad and extended family, my friends, and colleagues at work for showing interest in the many discussions we had about this project. Your enthusiasm provided me the courage to continue.

To Dr. Graham Swanson and Margaret Dorcas, thank you for sharing with me your stories about health, diabetes, and life. I look forward to continuing our discussions.

Thank you to the numerous patients who shared their illness journeys with me. This has been a privilege, and I continue to learn from your experiences as we work together in the healing space.

Finally, I dedicate this project to my sister, Marlene. Your wisdom guides me and I miss you every day.

## Table of Contents

	Page
Abstract .....	ii
Prologue .....	iii
Acknowledgement/Dedication .....	v
List of Figures .....	viii
 <b>CHAPTER ONE: INTRODUCTION</b> .....	 1
Wild Geese .....	1
Background .....	3
Patient Empowerment .....	4
Purpose of the Study .....	4
Outline of the Remainder of the Document .....	5
 <b>CHAPTER TWO: THEORETICAL FRAMEWORK</b> .....	 7
Grief and Meaning-Making .....	7
Professional Identity .....	8
Transformational Learning .....	11
Holistic Perspective on Transformational Learning .....	12
Healing Space .....	13
Conclusion .....	16
 <b>CHAPTER THREE: RESEARCH METHODS</b> .....	 18
Writing About Self .....	19
Relating to Self and Others .....	20
Method (Data Generation) .....	21
Vulnerability .....	21
Assessing Autoethnography .....	23
Ethical Considerations .....	24
Conclusion .....	24
 <b>CHAPTER FOUR: POETRY, STORIES AND REFLECTIONS</b> .....	 26
Knowledge Exchange in the Healing Space .....	26
Food in the Healing Space .....	40
Empathy in the Healing Space .....	45
 <b>CHAPTER FIVE: MY BEING AS A DIABETES EDUCATOR</b> .....	 54
Application to Practice .....	59
 <b>CHAPTER SIX: MOVING FORWARD</b> .....	 60
References .....	63

## List of Figures

Figure	Page
1: Framework to Analyze Professional Identity.....	15



## CHAPTER ONE: INTRODUCTION

### Wild Geese

You do not have to be good.  
 You do not have to walk on your knees  
 For a hundred miles through the desert, repenting.  
 You only have to let the soft animal of your body love what it loves.  
 Tell me about your despair, yours, and I will tell you mine.  
 Meanwhile the world goes on.  
 Meanwhile the sun and the clear pebbles of the rain  
 are moving across the landscapes,  
 over the prairies and the deep trees,  
 the mountains and the rivers.  
 Meanwhile the wild geese, high in the clean blue air,  
 are heading home again.  
 Whoever you are, no matter how lonely,  
 the world offers itself to your imagination,  
 calls to you like the wild geese, harsh and exciting  
 over and over announcing your place  
 in the family of things. (Oliver, 1986, p.14)

*“The Mediterranean room has been booked,” he informs me as we discuss the memorial plans.*

*“Oh, that’s good,” I reply and check it from the list of activities to do. “She wanted that room for the memorial. It’s bright, and there are plants everywhere.”*

*“What about food?” I question him. “We have to have food after the service.”*

*“Lots of food,” he agrees. “We have to have sushi and desserts.”*

*“I’ll talk to Mom, and we can get people to make squares for the event,” I offer.*

*The doorbell rings and he gets up to answer.*

*“Hi. I have a package delivery,” informs the courier.*

*He signs for the package and then comes back to the kitchen table where we had been working all morning. The table was covered with photographs for us to use at the service.*

*He opens the package and sees the book, Dream Work. “She ordered this book weeks ago. She always talked about Mary Oliver poetry. Now, the book is here and she’s not here to read it,” he cries. “I can’t believe she did that.” We are silent as we are stunned that this happened.*

*I note how eerie this seems. She was organizing her own memorial and making sure we had the poetry to read. I recall her conversation about what she wanted at the memorial service. She wanted poetry read. “Maybe read something like Mary Oliver’s (1986) ‘Wild Geese,’” she suggested.*

*I turn to the poem and read it quickly. I begin to wonder when this poem should be read during the order of service. I glance at the title “Wild Geese” and I think about some artwork we bought for Mom and Dad to celebrate their 50<sup>th</sup> wedding anniversary 6 months ago. It was a picture of two geese flying together. It seemed coincidental she selected that poem. Did she like the poem because of this artwork?*

*The poem didn’t seem too long. “Probably a good way to begin the service,” I suggest and then ask, “Are you reading this poem at the beginning of the service? Do you think we should have music following this piece?”*

This is an autoethnography of how my personal loss of a family member has contributed to a transformation in my professional identity as an adult diabetes educator. Through autoethnographic methods, I generate stories to describe and analyze the lived experience of participating in my sister’s breast cancer journey. In the opening vignette, I casually read and attached no meaning to Oliver’s (1986) “Wild Geese”. I read the poem in a superficial manner, as I was focused on the details of my sister’s memorial service. Through this research, “Wild Geese” provides a connecting point for reflection of a

personal loss experience to my professional identity transformation. By unpacking the generated stories and using poetry, I conduct a process of critical and self-reflection to discover how my identity as a health professional has transformed and what makes meaning in my role as a diabetes educator. I analyze my own self-story to uncover and examine the patient and health care provider discourse and explore the health culture. I discover a transformative experience of my identity from a health care professional who transmits specialized knowledge and focuses on evidence-based medicine to a more inclusive, holistic, and humanistic health care professional who values patient connection, therapeutic alliance, and mindfulness with patients and with self. Although this journey was by no means linear or prescriptive, it was evolutionary and ultimately transformative.

### **Background**

This research was an outgrowth of my work as an adult diabetes educator. For the past 20 years, I have been a Registered Dietitian and have been employed in the inpatient setting and in the outpatient chronic disease setting. I currently provide diabetes education in a diabetes education centre affiliated with a community hospital in a tax-based, publicly funded health care system. I am a member of the College of Dietitians of Ontario, a self-regulated college whose mandate is to establish and maintain professional standards of qualification, practice, knowledge, skill, and ethics (Regulated Health Professions Act, 1991).

I help adults manage their diabetes. Diabetes management requires several self-care activities such as eating well, exercising regularly, taking medications, and monitoring blood glucose, blood pressure, and blood cholesterol values (Tang, Funnell,

& Anderson, 2006). The goal in diabetes education is to empower individuals with diabetes to participate in their diabetes management by changing their lifestyles and adopting new self-care behaviours.

### **Patient Empowerment**

Patient empowerment encourages individuals to make autonomous informed health decisions and to incorporate self-care activities that can facilitate good diabetes management. In order to help individuals with diabetes and facilitate patient empowerment, Anderson & Funnell (2008) suggest diabetes educators need interpersonal skills, values, and personal traits that cultivate relationships with patients. Although empowerment is accepted theoretically, debate exists if empowerment is practiced in the current biomedical model with health care professionals socialized to focus on evidence-based health outcomes such as control of blood glucose, blood pressure, and blood cholesterol levels (Anderson & Funnell, 2008). I began to wonder if there is too much emphasis on the biomedicine and less on the human relations aspect of diabetes. I began to question my experiences in diabetes education and how I counsel patients. I was seeing a need to analyze my professional self or my professional identity.

### **Purpose of the Study**

The purpose of this research is to discuss how the meaning of a personal illness and loss experience has assisted in my personal development and has transformed my professional self. Even though I have seen illness and death for more than 20 years, I am using autoethnography to make sense of an illness and death experience that was new to me. I want to explore a variety of subject positions in the culture of health care through my sister's illness. Davis and Harré (1990) define a subject position as a created and

negotiated position of the self in interaction with other people using language in the process. I review the subject position of a health care professional and the subject position of someone with illness and the language used in the various subject positions.

Using Trede's (2012) concepts of professional identity and Cranton and Roy's (2003) holistic perspective on transformative learning, I discover a belief change and analyze how this belief change has caused me to position myself differently in my lifeworld of health care and how I act upon these beliefs. I move from an objectivist, evidence-based approach to a more humanist approach that values relational, connected ways of knowing that may facilitate patient relationships and patient empowerment. The experiential lens of examining how health care professionals interact in the health care setting allows me to discover a transformation in my professional identity shaping my current praxis as a health educator. My current worldview has not fully displaced my previous belief system. Rather, they coexist and combine to form a revitalized belief system. This modified belief system arises from observations and conflict from the old belief system.

### **Outline of the Remainder of the Document**

Chapter Two reviews the related and relevant literature and provides a theoretical framework. The literature discussed pertains to grief, professional identity, transformative theories, a holistic perspective on transformational learning, the health culture, and the healing space.

Chapter Three deals with the methodology and procedures used in this study. Autoethnography is the method chosen to generate narratives of my personal illness experience and to connect these stories to the health culture to analyze my professional

identity. Poetry is integrated to provide an additional method of knowing. Through a process of reflection on the narratives and poetry, I begin to find meaning in my loss.

Chapter Four reveals the stories, poetry and reflection and discusses three themes: knowledge exchange, food, and empathy, created from the integration of the poem “Wild Geese” to the narratives.

Chapter Five provides reflections on how these themes have transformed my professional identity, my being as a diabetes educator, and I consider applications to my professional practice. Connection, therapeutic alliance, and mindfulness are important qualities that emerge and can bring me to a more authentic self that I have in the healing space.

Chapter Six concludes with final thoughts of my experience using autoethnography as a research method to understand my personal and professional selves. The incorporation of story, poetry, and reflection helps me understand new insights into my self, and a more authentic self emerges in my professional identity in the health culture.

## CHAPTER TWO: THEORETICAL FRAMEWORK

In this chapter, I provide an overview of the theoretical framework I used in this research and I incorporate my reflections on the application of the theories to my analysis of my professional practice as a diabetes educator. I begin with a discussion of grief and how finding meaning in my grief led me to my research in the health care context.

### Grief and Meaning-Making

Freud (1917/1957) in his seminal work “Mourning and Melancholia” suggested detachment from the deceased was necessary before mourning could be completed. Freud argued a grieving individual must eventually let go of bonds, goals, and memories associated with the deceased to successfully adapt and invest in new relationships (Hoppes & Segal, 2010). Similarly, Bowlby (1980) and Kübler-Ross (1969) provided linear stage models of grief resolution that required a reorganization of life, knowing a permanent separation exists. I struggled with this concept. Detaching myself from my sister was impossible, and my mourning seemed endless, unpredictable, and without resolution.

Current grief theories (Attig, 2001; Neimeyer, 2001) propose healthy mourning involves meaning reconstruction that allows continuing bonds with the deceased person and renews the lives of those left behind. Reconstructing or developing new meaning after loss helps me to remain attached to my sister and to move forward.

Viktor Frankl (1946/2006), a Nazi concentration camp survivor, indicates that the fundamental quest for humans is the search for meaning, the “will to meaning” (p. 99), and suggests, “suffering ceases to be suffering the moment it finds meaning” (p. 113). In the period following my sister’s death, I was searching and doing. I wanted to understand

what this painful experience was about, what it meant to me. I was searching for meaning. Could this happen after my loss?

Meaning-making can provide “order and direction to the choices we make about how to live our lives” (Muncey, 2010, p. 15) and can form a bridge between learning and development (K. Taylor, Marineau & Fiddler, 2000). With this in mind, I began to consider the meaning of illness experience. As I was a primary support during my sister’s illness, I had the opportunity to witness her journey of breast cancer. I began to reflect on the experience of illness from both the health care professional perspective and the perspective of the ill individual. I asked the questions, “What happened here?” “How did I come to think this way?” and “Why is this important?” (Cranton & Roy, 2003, p. 88). I was questioning my professional activity in health care as I was questioning what I was doing and why I was doing it (Trede, 2012). These questions were contributing to a disorienting dilemma (Mezirow, 1991) and became an important pedagogical entry point (Lange, 2004) for transformational learning in search of a revised version of how I saw myself as a health care professional, a revised professional identity.

### **Professional Identity**

Professional identity can be “defined as one’s professional self-concept based on attributes, beliefs, values, motives, and experiences” (Slay & Smith, 2011, p. 86). Although professional identity is a frequent topic for review, diverse meanings of this concept exist. Sociologists such as Mead (1934) and Parsons (1964) and philosopher C. Taylor (1992) suggest individual identity is a socially constructed phenomenon and, when examining professional identity, a similar socially constructed viewpoint can occur.



Trede (2012) has positioned professional identity into three broad concepts:

1. the conscious self at the centre of professional identity development,
2. the power of social relations, and
3. the power of language and discourse.

Professional identity is both an internal and external concept and is affected by how a professional views him/herself and how others view the professional through social discourse and the exchange of language (Trede, 2012).

Identity is not fixed, and it is always in a process of fluidity based on critical learning experiences (Trede, 2012). “Professional identity is interdependent with the structural context and the situations of others” (Trede, 2012, p. 162), and is the “socially constructed nature of our current experiences” (Jackson, 2009, p. 246). Cooper and Olson (1996) and Reynolds (1996) investigated the interconnections between the personal and professional elements of teachers’ identities. Multiple selves of teachers are continually reconstructed through the historical, cultural, sociological, and psychological influences which all shape the meaning of being a teacher.

Identity formation is an ongoing process that involves the interpretation and reinterpretation of our experiences as we live through them – suggesting that focusing on transactive relationships rather than linear models might provide a deeper understanding of the multiple ‘I’s’ of teacher identity . . . teacher identity is continually being informed, formed, and reformed as individuals develop over time and through interaction with others. (Cooper & Olson, 1996, p. 80)

I consider the effect of personal loss on my health educator professional identity.

This is but one aspect of my professional identity. Other components such as political and

institutional experiences have an effect on how I identify myself as a diabetes educator. I choose to focus, however, on a personal experience and analyze the transformative effect.

Professionals view professional attitudes known as “professionalism” as a framework to identify their work in a social context (Fagermoen, 1997). Professional socialization is “the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge – in short, the culture – current in groups of which they are, or seek to become, a member” (Merton, Reader, & Kendall, as cited in Clouder, 2003, p. 213). In my culture of health, through a process of enculturation and professional socialization, I adopt attitudes, beliefs, and actions that help me define my membership in this professional group.

Professionals struggle to articulate their professional values and commitments (Trede, 2012) as values and moral principles often remain hidden and not conscious (Nyström, 2009). Anderson and Funnell (2010) state:

During their professional education, HCPs [health care providers] are socialized to a set of responsibilities and expectations that define their professional identity.

These responsibilities and expectations become so embedded in their professional identity they do not consciously think about them; rather they see their practices through them. (p. 278)

Before my personal loss, I adopted a set of attitudes, behaviours, and values that I felt were important in diabetes education. I focused on diabetes biomedical markers such as blood glucose levels, as I wanted to help the patient. I believed intellectually in the patient empowerment approach for diabetes education. However, socialized as a health

care professional, I may have behaved in ways that completely contradicted it and was not aware of the contradiction (Anderson & Funnell, 2010).

Through a reflection process of self-narratives and poetry integration, I begin to articulate my professional values as I consider how my conscious self and my self that is visible to others have changed in the health life world after personal loss. I examine the variety of discourses in the health care culture—from a health care professional perspective and from a patient perspective. I analyze the forms of language expression to help me understand who I am.

“Professional identity formation means becoming aware of what matters most in practice, what values and interests shape decision making” (Trede, 2012, p. 163).

This sense of self affects our relation to the world and gives us a unique character.

Transformational learning is the process that has the potential to understand and change my professional values and help me to identify what matters most in my practice.

### **Transformational Learning**

For nearly 40 years, transformative learning has been a topic of interest in both the academic community and the world of practice. Based on the work of Mezirow (1991, 2000) and Cranton (1994, 2002), transformative learning can be described as “a process by which previously uncritically assimilated assumptions, beliefs, values, and perspectives are questioned and thereby become more open, permeable, and better validated” (Cranton & Roy, 2003, p. 87).

Through a process of engagement, discourse, and critical reflection, our assumptions of values, beliefs, and attitudes through which we understand experience,

our “frames of reference” are altered, leading to paradigmatic and behavioural shifts (Cranton 2006; Mezirow, 1991, 2000; E. M. Taylor, 2007).

Reexamination of assumptions and values and critical thinking requires critical reflection, and Merriam (2004) argues, “mature cognitive development is foundational to engaging in critical reflection and rational discourse necessary for transformative learning” (p. 65). A rational, cognitive approach is proposed as a prerequisite for transformational learning to occur.

Alternative forms of transformative learning using experiential and expressive ways of knowing suggest one’s affective and spiritual self can assist in making one’s self more conscious. Davis-Manigaulte, Yorks, & Kasl (2006) suggest experiential knowing, though not easily communicated to either oneself or to others, utilizes emotions that affect people’s way of being in the world. Poetry is a form of expression that may create accessibility to obscure, elusive, yet deeply meaningful knowing (V. Holmes & Gregory, 1998).

### **Holistic Perspective on Transformational Learning**

The various transformation processes have fragmented the interpretation of transformation learning theory. Cranton and Roy (2003) propose a more inclusive approach that encompasses various cognitive, affective, and spiritual methods that can coexist within a holistic perspective. It is this holistic perspective that I consider when I examine my transformational learning. I use poetry and self-narratives as ways of expressive knowing to help me bring the affective into consciousness. “These ways of knowing can create an encapsulation of complex experiences and ideas. If a learner creates an expressive representation of a new insight, he or she can later relive the entire

learning experience by re-experiencing the expressive representation” (Davis-Manigaulte et al., 2006, p. 32). Throughout the retelling of these narratives and the connection to the poem “Wild Geese” (Oliver, 1986), I relive and feel the experience of illness and loss. I use cognitive, rational ways of knowing to reflect on the health culture and how my personal experience has transformed my professional health identity.

Transformation of professional identity involves self, self-reflection, the social relations in the professional practice, and the social discourse in the professional community through the use of language. Through transformational learning, changes in my assumptions and perspectives exist, creating changes in my self (Cranton & Roy, 2003). This leads to a more whole and authentic self that I can bring to the healing space of my profession as a diabetes dietitian educator.

### **Healing Space**

When an individual has a health crisis, he/she can be cured or healed in the health care world (Hutchinson, Hutchinson, & Arnaert, 2009). In the curing mode, the goal of the patient is survival of the current state. This involves not only physical survival; rather, it encompasses all that patient has learned to identify him/herself including physical appearance, lifestyle, relationships, and other factors that create a life. In curing, the patient depends on the expertise of the practitioner to control the disease, and the patient does not require a change in items that identify himself/herself (Hutchinson et al., 2009).

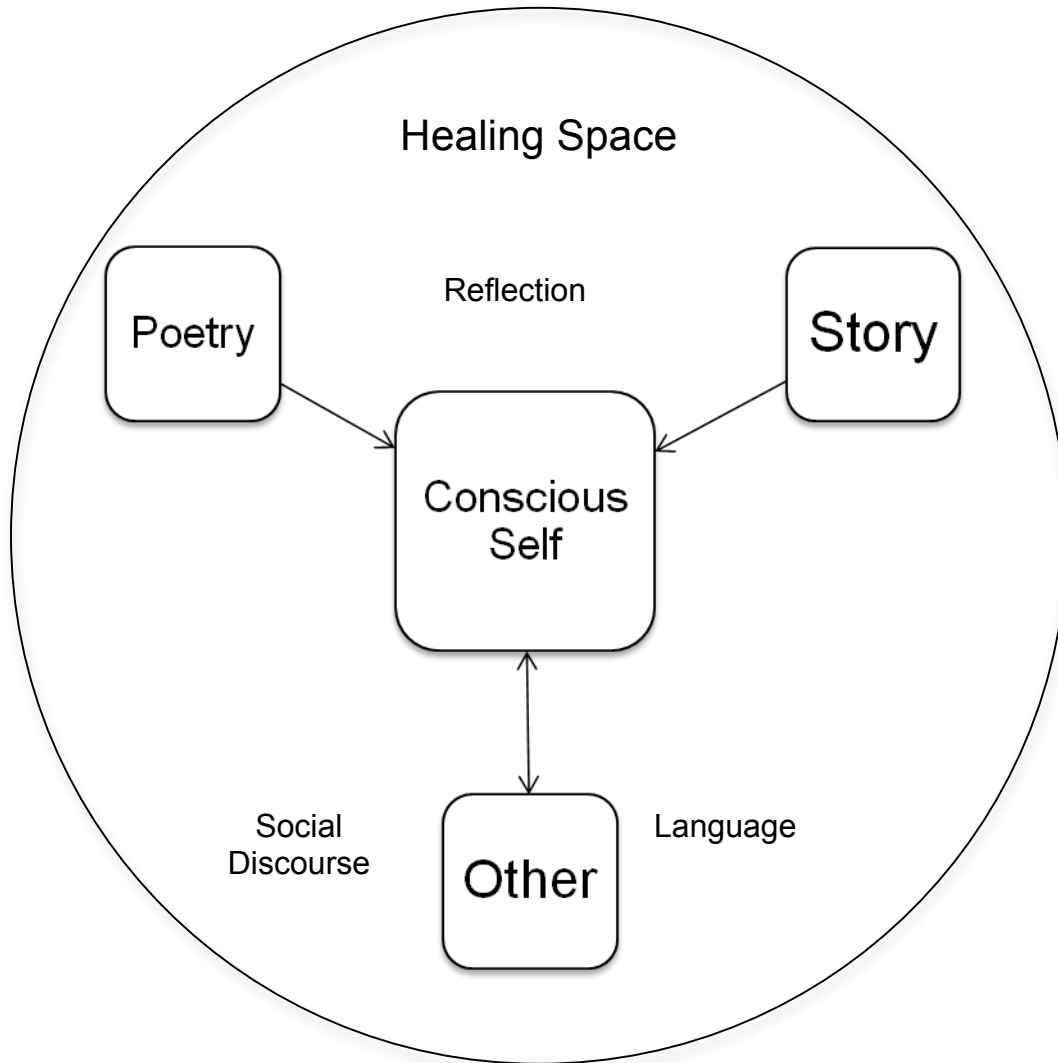
Healing, on the other hand, comes from the realization and acceptance of change. “In healing, the patient begins to realize that it is his or her own resources that will finally lead to growth and that he or she is responsible for managing those resources” (Hutchinson et al., 2009, p. 845). The health care professional participates in healing in

conjunction with the patient. The patient, however, is deciding the changes and acting upon those decisions.

Mount (2006) discusses healing as an experience of integrity, wholeness, and inner peace that transcends suffering and suggests a need for the healer (health care professional) to create a space where healing can happen. A healing presence impacts on both meaning and connectedness—factors strongly associated with a sense of well-being (Mount, 2006). Creating a healing space can create shared meanings and a relational process that reduces suffering, encourages healing, and contributes to the effectiveness of the treatments (Pohlman, Cibulka, Palmer, Lorenz, & SmithBattle, 2013).

Diabetes is a chronic disease that cannot be cured; therefore, healing is the goal of health care intervention with the patient requiring participation in a new way of living. As healing is a “lifelong journey and process of bringing together aspects of oneself at deeper levels of harmony and inner knowing leading toward integration” (Pohlman et al., 2013, p. 71), treating the whole patient and not just the disease can be considered. It is with this in mind that I consider my contributions to the diabetes healing space while reflecting on my professional identity transformation after personal loss.

Figure 1 illustrates the theoretical framework I use in this research. I represent my professional self in the healing space and offer a possibility that my professional self may be transformed after understanding my personal self after illness and loss. Trede’s (2012) concepts of professional identity are presented, with the conscious self constantly in interaction with the other through language and social discourse. To make my self more conscious, I have incorporated autoethnography and have used poetry, story, and reflection to understand my self in relation to others in the health culture.



*Figure 1.* Framework to analyze professional identity.

## **Conclusion**

In this chapter, I discussed various grief models and suggested that Attig's (2001) and Neimeyer's (2001) theories of meaning construction after loss allow me to remain attached to my sister as I move forward in my life. I choose to understand and find meaning in the illness experience and analyze how these new understandings affect how I see myself and how others see me as a diabetes educator. I wish to understand my professional identity and determine if my identity has been transformed.

I reviewed Trede's (2012) position on professional identity and suggest that three broad concepts are involved in examining professional identity. These concepts are:

1. the conscious self at the centre of professional identity development
2. social relations
3. involvement of language and discourse.

Professional identity is affected by the professional's own internal concepts and by those reflected back to the professional by external sources through social discourse and the use of language. Professional identity may change based on context and has a variety of influences including personal experiences. I chose to examine the influence of my personal illness experience and loss of my sister to determine if this personal experience has had a transformative effect on professional identity.

Citing works from Mezirow (1991, 2000), Cranton (1994, 2002), Merriam (2004), and Davis-Manigaulte et al., (2006), I discussed various transformation theories and processes in transformational learning. I proposed Cranton and Roy's (2003) holistic perspective on transformational learning as the model to be implemented. Rather than a fragmented approach, I considered the cognitive, affective, and spiritual approaches in



the transformation process and included a holistic method in transformational learning through story, poetry, and reflection.

I concluded the chapter by analyzing the health culture and highlighting the difference between curing and healing as outlined by Hutchinson et al. (2009). Curing depends on the expertise of the health care practitioner to control the disease. The patient does not require a change in items that identify himself/herself. Healing requires change from the patient, who determines the best resources to manage his/her health. Diabetes is a chronic condition that cannot be cured; therefore, healing is the goal of health care intervention, with the patient requiring participation in a new way of living. Treating the whole patient and not just the disease is considered to reduce suffering and encourage healing, and Mount (2006) suggests creation of a healing space that can create shared meanings and a relational process between the patient and the health care professional.

### CHAPTER THREE: RESEARCH METHODS

Autoethnography is a form of narrative and research connecting the personal to the cultural and places the self within a social context (Reed-Danahay, 1997). I chose autoethnography as a method of research to examine and make meaning of the illness experience from the perspectives of both the self and the other in a health care culture. I have observed the “other” who experiences illness in my identity as a health care educator. With my sister’s breast cancer, I became part of the “other” and was no longer the health professional. Accompanying her on an illness journey, I witnessed the health care culture from the patient’s perspective. By researching self and the other through the autoethnographic approach, I have the unique opportunity of exploring “the multiple layers of consciousness connecting the personal to the cultural” (Ellis & Bochner, 2000, p. 739). My research goal is to focus on the health culture experience both as a health care professional (self) and as an individual witnessing health care given (other) and to gain a better understanding of the health experience.

Although I wish to express the “other” perspective, I recognize it is one of many perceptions of an illness experience. “There is no neutral space from which we write, or from which we read. As well as our past experiences, we bring our present locations, and the immanence of futures that are opaque and that offer multiplicitous possibilities” (Gannon, 2013, p. 230). I retell my own personal and professional experiences with an attempt to understand my self and my relations to others in my current position in health care.

### **Writing About Self**

I chose to use autoethnography to write my story and to maneuver through a period of my life of pain, confusion, anger, and uncertainty (Holman Jones, Adams, & Ellis, 2013). Writing is a method of relating (Poulos, 2013). By writing my stories, I explore and interrogate my self in the culture of health, allowing a deeper understanding of my own values in relation to others (Starr, 2010). Using autoethnography as an emergent method of inquiry (Richardson, 2000) with reflection in and on practice (Schön, 1987), I discover new beginnings in my professional life.

All parts of myself—emotional, spiritual, intellectual, embodied, and moral—are presented in this autoethnography (Bochner, 2013). Poetry and the creation of narratives helped me integrate a spiritual component of my self as I try to make meaning from the loss of my sister. My pain and suffering is relived as I reread the narratives. My reflections on these experiences required a cognitive and moral understanding. By knowing my self better through this process of reflection, I find myself able to relate better to others.

The self, the individual, is a highly reflexive, historically positioned entity, who attempts to engage in meaningful relationships with their culture, their society and other individuals. Like an iceberg, only a fraction of them is visible and autoethnography attempts to increase this visibility to provide a wider range of stories for individuals to connect with. (Muncey, 2010, p. 23)

Through autoethnographic methods of self-narratives and poetry integration, I hope to gain a better understanding of my self that I can apply to my professional practice.

### **Relating to Self and Others**

Heron and Reason (2001, as cited in Yorks & Kasl, 2006) suggest “researchers engaged in human inquiry cannot position themselves as disconnected from the experience into which they are inquiring” (p. 50). I am reviewing my helping and healing professional identities, which involves an inquiry into human interactions and human communication. Therefore, an analysis of self is necessary.

Telling our stories is a way for us to be present to each other, provides a space for us to create a relationship embodied in the performance of writing and reading that is reflective, critical, loving, and chosen in solidarity. (Holman Jones, 2011, p. 333)

The autoethnography created helps me visualize and interpret the health culture through self-reflections and cultural refractions of my identity as a health educator (Spry, 2001). Through this research, I ask myself tough questions on how I perform as a health educator in the health care culture. I want to hear a patient voice. The subjects in many research studies I review are hidden, neutral, and have no voice. Through autoethnography, I have the opportunity to use my personal and professional experience in the health culture reflexively and “to bend back on self and look more deeply at self-other interactions” (Ellis & Bochner, 2000, p. 740). Reviewing the self-narratives and the display of emails exchanged during my sister’s illness allows me to hear a voice of an “other” and to hear my voice.

This study is a health professional identity analysis, but it is not a complete identity review. My identity is fluid and always changing. “The self produced in a text is always contingent, tentative, situated and relational” (Gannon, 2006, p. 476). In this

study, I have focused on a personal experience and the impact this has had on my professional identity. I have not considered other factors related to identity—historical and political aspects, social interactions with colleagues that contribute to how I see myself as a professional. As I continue to be a diabetes educator, other experiences and social forces will impact on how I see myself as a professional and how others see me.

### **Method (Data Generation)**

Using personal experiences as primary data for social analysis, my autoethnography draws on autobiographic data of memories, emails between family members during my sister's illness, my College of Dietitians' quality assurance submissions, interviews with others, and my ongoing self-reflective and self-observational memos. Using a variety of sources to generate the narratives gives richness to the emerged text (Muncey, 2010).

I also include Mary Oliver's (1986) poem "Wild Geese" to provide additional knowing and reflection. Using poetry can help me generate new ways of thinking and "trouble the unconscious into recognizing new ways of looking at and reflecting on experience" (Muncey, 2010, p. 59). I may uncover new learning that was not conscious in my professional and personal worlds.

### **Vulnerability**

Autoethnography is a highly personal and highly social process (Chang, 2013); therefore, researching and writing placed me in a state of vulnerability. As I wrote my narratives, I wrote my self into being from a particular position that took me places that were emotional and difficult to navigate. I relived the anxiety I felt when my sister was ill. It also required a significant use of self-disclosure and honesty (Foster, McAllister, &

O'Brien, 2006). I questioned how I was representing myself in my autoethnography (Wall, 2008). I was afraid of what readers would think of me as I participated in this new form of research. Perhaps I am afraid to reveal my vulnerable self.

Autoethnography has been labelled narcissistic, self-absorbed, and researcher self-indulgent (Foster et al., 2006). I wondered if I was focusing too much on my self as I was completing this project. Also, because of my scientific background, I was familiar with a research process that is an objective, neutral, structured, results-driven process where I could report on findings and I, as the researcher, could control for all variables. I questioned the appropriateness of autoethnography when I was introduced to this method of research. Initially, this type of research did not seem legitimate. So beginning and continuing this research project was difficult.

Clough (as cited in Gannon, 2013) states, "the process of autoethnography throws the writer backward and forward to find the self that is turned into parts, turned around parts of a new assemblage" (p. 233). This process was not uni-directional and did not provide final conclusions. I was accustomed to traditional research that provided objective information that was generalizable to all individuals. I felt the research might not be complete and there were no valuable conclusions that I could present.

But I persevered. I kept returning to my desire to find meaning in the lived experience of personal illness and death, and I felt autoethnography could help me achieve this purpose. After conducting this research, I feel autoethnography expands my meaning of research and has increased my ways of knowing in my personal and professional worlds. "Whereas empiricist social science fuels an appetite for abstracts, facts and control, autoethnography feeds a hunger for details, meanings, and peace of

mind” (Bochner, 2013, p. 53). Writing my narratives required me to express myself evocatively and creatively. Autoethnography provides an opportunity for “conversation through which we can come to know ourselves and others and the positions from which we speak; a conversation that unites the humanities and the sciences” (Ellis & Flaherty, 1992, p. 6). Autoethnography allowed me to reflect on my interactions as a diabetes educator and to gain further insight in my professional life.

### **Assessing Autoethnography**

Using traditional, positivist standards to assess the trustworthiness and accuracy of autoethnography can be difficult. Did I recall every detail in my narrative as it actually happened? To assess autoethnography, Muncey (2010) proposes using a social constructionist perspective where no one certain truth exists and that truth, created through social constructions, can help inform understanding of the concepts of “self” and “other,” and that reality is subjective. A concept of “verisimilitude” or lifelikeness (Ellis, 2004) is used to judge autoethnography as trustworthy. This requires the narratives to “evoke in your readers a feeling that your experience is described as lifelike, believable and possible” (Ellis, 1999, p. 674). If the narratives are lifelike, these stories become useful in “their capacity to inspire conversation from the point of view of the readers, who enter from the perspective of their own lives” (Ellis & Bochner, 2000, p. 748). I have tried to create narratives that the reader can feel and believe to be lifelike. If the readers feel the narratives to be lifelike, I have used autoethnography as a method to gain insights into my social reality of the health culture.

### **Ethical Considerations**

This autoethnography had an initial research ethics review at my place of academic study. Further formal ethics board approval was not required. But I still consider the ethical considerations in this type of research. According to Ellis (2009), “writing about yourself always involves writing about others” (p. 13), and I had to consider the personal, social, political, and ethical consequences of using my experiences as the source of research data (Tullis, 2013). I used pseudonyms and composites of health care professionals when I created the narratives. I was mindful of individual privacy rights, and I considered the life of the story once it became published (Tullis, 2013). I included my sister’s name in the email exchanges; however, I selected email exchanges that respected her privacy and dignity, as there are “ethical responsibilities toward intimate others who are implicated in the stories we write about ourselves” (Ellis, 2007, p. 5). I also considered ethics of self by monitoring my emotional self when I was reading my exchanged emails with my sister and generating and analyzing the narratives. When reliving these experiences, I was evoking strong emotions.

### **Conclusion**

Autoethnography is the method I have chosen to research a possible transformation of my professional identity. In this review, I discussed what autoethnography is and why I chose to use this method for my research. I reviewed how autoethnography can provide a reflexive process of my self and other in the culture of health. I utilized a variety of sources to generate personal illness stories, and I connected these stories to poetry for further meaning. I discussed how the process of autoethnography made me feel vulnerable, and I reviewed the ethics I considered when I



created my autoethnography. Even though I had hesitations about this research initially, I found the autoethnographic method an appropriate method to find meaning in illness and loss and a method of relating to my self and to the other. My goal is to create an autoethnography to which the reader can relate and can gain insights into the health culture by hearing my personal story.

In Chapter Four, the Poetry, Story, and Reflections chapter, I begin with phrases from “Wild Geese”. I follow with vignettes of professional situations and then personal illness experiences that lead me to question my attitudes and values in my diabetes profession and to discover if my identity as a diabetes educator has in fact gone through a transformation.

## CHAPTER FOUR: POETRY, STORIES AND REFLECTION

*You do not have to be good.  
You do not have to walk on your knees  
For a hundred miles through the desert, repenting. (Oliver, 1986, p.14)*

### Knowledge Exchange in the Healing Space

In the first section of this chapter, I provide stories of how I discover a transformation in my ways of knowing in my professional life as a diabetes educator. I review how I historically would receive knowledge for professional development and how I identify new ways of knowing in the healing space. I begin with an email that I sent out to my family days before I began a new position as a diabetes educator dietitian.

#### New Job as a Diabetes Educator Dietitian

*To: Family  
From: Cheryl  
Subject: My news*

*Hi everyone.*

*Just wanted to share my news about my new job. I have been hired to be a diabetes educator dietitian. I start on March 24th and I will be working three days a week. Don't know what days I will be working - have to sort out the details. I have lots of reading and updating to do. Thank goodness we are going spend the week with Chris' parents. They can be with the kids while I update from an eight-year absence! I will be reading the Canadian Diabetes Association clinical practice guidelines. There is so much to learn and remember. I want to get through the guidelines before I start work. Happy March Break!*

*Cheryl*

Reviewing this email again, I recall the urgency I felt to read and know these practice guidelines before I started my employment. It was important to me to demonstrate to patients and work colleagues my diabetes knowledge by knowing the clinical practice guidelines in the culture of evidence-based medicine.

### **Evidence-Based Medicine**

Clinical practice guidelines are an increasingly familiar part of health care and part of a larger evidence-based medicine movement. Evidence-based practice has emerged in medicine using rigorous research methods to identify best practices that minimize potential harm of clinical interventions. Clinical practice guidelines, a subset of evidence-based medicine, itemize best practice approaches for a variety of medical conditions.

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systemic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice.

(Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71)

The purpose of evidence-based medicine is to ensure safe, updated, efficient care is present. With evidence-based medicine, a potential for a standardized method to approach health care may occur, with a possibility that the human component of illness is lost. “An evidence-based, empirical world view is dangerously reductive insofar as it

negates the personal and interpersonal significance and meaning of a world that is first and foremost a *relational* world, and not a fixed set of objects, *partes extra partes*” (D. Holmes, Murray, Perron, & Rail, 2006, p. 183).

Evidence-based practice was the traditional objectivist scientific source of knowledge that consciously dominated my diabetes practice. It was important to me to know every clinical practice guideline related to diabetes, and my professional value had been defined by how much I knew about the diabetes clinical practice guidelines. In the health care culture, an emphasis exists on “evidence, technologies, techniques, and outcome measurements and necessitates a shift in the focus of practice, characterized by a rapid move from ‘being’ to ‘doing’” (Stickley & Freshwater, 2006, p. 14). There is an emphasis to follow a standardized method using the practice guidelines to produce consistent results, to do the right thing and always the same way.

I insisted on perfection. When I read the first phrase “*To be good*” in Mary Oliver’s (1986) “Wild Geese” poem, I connect knowing and following the practice guidelines as the defining criteria of a “good” diabetes educator with high standards. Disciplinary knowledge and technical skills were the priorities in my identification of my professional self as described by Habermas’s (1971) analysis of instrumental knowledge where knowledge is based on empirical investigation and governed by technical rules.

Professional development was updating my diabetes knowledge base by reviewing the revised practice guidelines. Kegan (2000) distinguishes between “informative learning,” which brings about changes in “*what* we know,” and “transformative learning,” which brings about changes in “*how* we know” (p. 50). In my practice of diabetes education before my sister’s illness, I focused on informative

learning to maintain or improve my diabetes knowledge. My belief was that if I knew these practice guidelines, I would be able to provide good diabetes education to patients that I counseled. What follows is the beginning of narratives that provided entry points into my transformative learning that changed the process in how I knew and an entry into other ways of knowing.

### **Breast Cancer Diagnosis**

*I spray the window cleaner on my front window. I have to keep busy. I know she will get the results today. She had the biopsy last week and should hear the results today. I busily rub the window to remove all the streaks and dirt. The phone rings.*

*“It’s breast cancer,” she tells me, crying through her words.*

*I feel a piercing sensation in my chest. “What? That can’t be.”*

*“Yes. It’s cancer.”*

*“But the lump is not in your breast. It’s in between your breasts.”*

*“It’s in breast tissue.”*

*“What kind of tumour? What did the pathology say? Is it estrogen positive? If it is, I’ve heard people going on tamoxifen.”*

*“I don’t know what it is. I didn’t expect this. This is so unfair. We were starting a new life with our daughter and now what? I wanted to spend the summer with her. Now what summer will I have? I can’t believe this is happening.”*

*“I’m so sorry this happened. Do you want me to come over?”*

*“No.”*

*Silence. What do I say? I can't believe this. My mind is whirling. What does this mean? Is there lymph node involvement? If so, she'll probably need chemotherapy.*

*Radiation? Mastectomy or lumpectomy?*

This was the beginning of my journey with my sister's breast cancer. Our conversation focused on the diagnosis of breast cancer and the shock that accompanied this diagnosis. It contains information about the breast cancer disease and the beginnings of an illness experience.

As I reflect on this story, I realize that at that moment, my way of knowing continued to focus on the biomedical way of knowing, the breast cancer disease. I wanted to know if the diagnosis was correct, and I began to speculate treatment. I began to use specialized knowledge and jargon used in the health care industry. We did begin discussions about the shock and disbelief with the diagnosis, but I felt as a member in a medical community my priority was to communicate the specialized knowledge I possessed to my sister.

Health care knowledge is a very specialized and technical knowledge. This specialized knowledge has a language that is distinct. By sharing this specialized information in various discourses in my health care world, my professional knowledge defines me and contributes to my professional identity.

With this technical and standardized methodological approach, is patient individuality a reality? Do I provide a unique service to the patients with diabetes, or am I an interchangeable cog in the health care wheel (Anderson & Funnell, 2008) that can provide the same, consistent, and standard information? Are there other contributions that I provide in the education encounter that affect the diabetes experience?

**What Is It? It's Breast Cancer**

*To: Family  
From: Marlene  
Subject: Yesterday*

*Hi all.*

*We had a long morning yesterday. The appointment was for 9 am, but we didn't get in till 10 am and got out of there about 12:30.*

*She has not seen this kind of lump before, in this location, but she thinks it's breast cancer and that this is the "primary" site. i.e. It started here in the lump, and it's not that there is cancer elsewhere in the breast and it has spread. She couldn't find any inflammation of lymph nodes or other lumps. So she is recommending a lumpectomy, followed by chemo & radiation. If all goes according to plan, I'm looking at about 9 months of treatment. Before I can have the surgery she wants an MRI of the breast, a mammogram, and a bone scan and a liver ultrasound.*

*It could have been worse, but I am not really willing to trust this diagnosis until more tests (and possibly also the surgery) are done. The surgery also involves injecting radioactive dye into the lymph nodes, taking out the "sentinel" lymph node & sending it off for tests while I'm still under. If it comes back positive for cancer, then they take out more lymph nodes. If not, that's it for lymph nodes. They used to take out quite a few lymph nodes to be sure.*

*I have ultrasound on Wed and mammogram & bone scan on Thurs. Still waiting to hear about the MRI and surgery date.*

*That's all for now. Love to everyone.*

*Marlene*

## Feeling Butchered

*I prepare the chicken sandwich for her lunch knowing she had a long wait this morning. She went to the hospital to pick up the results of the MRI. It was easier to go and physically transfer the report to the specialist's office. There was a pattern of test results being lost. She tried to do anything to make this experience less anxiety provoking.*

*She arrives and we sit down for a cup of tea. I see the exhaustion on her face.*

*"I had my MRI yesterday. I felt like I was being butchered when they put an IV in me. I'm so tired of having to deal with this."*

*"But you need to know the results. The MRI will tell you the results."*

*"It was horrible. I felt so awful. Putting me in the tube. And I have to have a bone scan tomorrow. Another long day that will exhaust me. I just wish this would all go away."*

As I reread these accounts of the early days of the breast cancer diagnosis, I relive my sister's experience accessing the health care system for support. Numerous tests were done to identify the diseased components of her body. Lupton (2012) suggests a fundamental difference between disease and illness. Disease is not unique to humans; animals or plants can be diseased (Lupton, 2012), and someone who is "diseased" denotes a "technical malfunction or deviation from the biological norm which is 'scientifically' diagnosed" (Lupton, 2012, p. 86). Illness is innately human and is the social, lived experience of symptoms and suffering. Individuals with illness recognize bodily processes are malfunctioning and seek treatment to improve the situation (Lupton, 2012).



I begin to see the differences in disease and illness while reading this narrative. My previous way of knowing working with individuals with diabetes would be to focus on the disease. Now, through recreating this narrative, I begin to understand the illness story. My sister describes a feeling of being “butchered” when having the MRI procedure done. How many patients do I know experience anxiety with the diagnostic and treatment options that are so often suggested? I take for granted the emotional component of diagnosis and treatment. I begin to wonder if I focus primarily on the disease of diabetes rather than the daily illness experience of living with diabetes.

When an individual becomes ill, a state of suffering and meaninglessness may happen to affect the illness experience, as “the present is not what the past was supposed to foreshadow, and the future is too frightening to contemplate” (Egnew, 2009, p. 171). A feeling of being different in society may be present (Egnew, 2009).

Because of my professional socialization, do I, as a health care provider, emphasize too much on the disease component compared to the illness experience? In order to diagnose and treat, the health system relies on technology for knowledge. “The medical apparatus bringing together various discourses, practices and objects in western societies is [equally] a product of social and cultural relations and systems” (Lupton, 2012, p. 166).

In my professional practice, I begin to question if I emphasize the socially constructed diabetes apparatus that focuses on biochemical outcomes. Markers such as blood glucose control, blood pressure, and blood cholesterol control dominate my practice. Do I consider other ways of knowing to learn about the patient’s illness experience?

## Treatment Decision

*To: Family*

*From: Marlene*

*Subject: Another update*

*Hi everyone.*

*Update on yesterday. The oncologist suggests chemo (4 1/2 - 6 1/2 months, depending on which one, she suggested two which have basically the same results: 1) FEC 100 & 2) AC + Taxol followed by radiation & also hormonal therapy (5-10 years). Side effects of chemo as expected (menopause, hair loss, nausea & vomiting, mouth sores, fatigue, "chemo brain" -- and then there are the "rarer" effects: leukemia, cardiotoxicity) -- hormones can also be nasty (you have to be in menopause, so they do that if you're not already, and also blood clots, endometrial cancer, weight gain, etc.)*

*The statistics are very confusing: hormone treatments reduce your chance of recurrence by 50%; & chance of mortality by 25%. And chemo adds on an extra 5% absolute benefit. The "absolute" numbers are 7% (hormonal) & 5% (chemo) = 12% reduction -- I think of recurrence, though she was speaking so fast it was hard to keep up. These are "reductions" only -- and if you're outside the stats, you're outside the stats.*

*Very little is done in terms of my individual situation. It's all about age, type of cancer, size & grade of tumour. Nothing about anything else other than: health: good. I asked the intern (forgot to ask the oncologist because they come through one after the other & it's hard to keep track of everything that comes up) about the elevated prolactin levels that I have due to the lesion on my pituitary gland. She said there has been no research done on this & a connection to breast cancer. Though last night (3 am) when I woke up, I was able to find information pretty quickly on studies that have established*

*this link. This is now controlled by a drug I'm taking, but how well does it work under a chemo regime? Again -- no answers.*

*We kept them much longer than we should have, but there was so much information & so many questions. Though they put so much emphasis on stats, on the first computer print out of my "case" (which gave a different graph-like breakdown of recurrence/mortality based on 100 women) had the wrong histologic grade of the tumour on it (which we caught) -- which made a difference -- slight -- but nonetheless, if you're supposed to be basing your decision on stats & such information, surely these details are crucial. It made a difference of about 9 % (in our favour -- so maybe that's as good as doing chemo? -- it felt like we got a "deal" at Goodwill finding that out).*

*There are no stats on alternative & complementary treatments & skepticism from them on this. The way we left it was to book a first chemo appointment as it's easier to cancel an appointment than it is to set one up at the last minute.*

*So that's that -- big decision ahead -- your input is welcome -- I know some of you are not keen about alternative & complementary treatments, but I am considering them & I do need to talk about them, even to sort through what I want to do. Ultimately I have to live with this decision & be okay with whatever I choose.*

*I am still not sleeping well and I am still crying a lot because I drift back into thinking about how I was so looking forward to spending the summer & fall with our daughter with some clear time. This has been, and continues to be so difficult & life changing for us. Also, we won't be able to adopt another child from China unless "cancer free" for a number of years. I am really trying to develop a more positive outlook but this doesn't come naturally to me so I'm having to work on this too.*

*I picked up a pamphlet on talking to people with cancer that I can copy for you or scan for you if you like if you're finding it difficult to be with and talk to me about this. From my point of view, there's no such thing as saying the wrong thing, so don't worry about that -- I am who I am and if I come across angry & frustrated that's because I am right now, and I need to vent & try to work things out. Love to all.*

### **She Needs to Start Chemotherapy**

*"Test your urine to make sure it is not too acidic, don't eat sugar, avoid red meat, only use organic food. Buy supplements." There are so many suggestions she is considering. Those people are selling hope. They don't have the answers. Their way is not scientific based. All they want to do is make money. And their way is the only way. "Forget medicine!" I say incredulously. "What is she thinking? She needs to start the chemo," I plead to him.*

*"How can I help?" I wonder. I hear about a conference for breast cancer targeted for health care professionals and women with breast cancer. I register us. This is what is familiar to me. Go to conferences. Get information. This will give us power and control.*

*We hear the oncologist speak. "If the breast cancer goes to other places, it is no longer treatable. This means you will not recover from the disease." I feel the oncologist's emphatic communication. She wants to let us know the real truth, clearly communicate to us. "It is no longer treatable"*

*Marlene looks at me with fear in her eyes. "That is what can happen to me." It makes me feel this is really happening.*

*Next up is a cancer researcher talking about the latest hormone treatments.*

*Aromatase inhibitors, newer drugs that have better results than tamoxifen. I understand the familiar language, relative risks versus absolute risks. Length of studies 5 years. Yes, important criteria to think about.*

*I furiously take notes, making sure I note the scientific journal citations. I look over and notice how silent Marlene is. I feel her fear and sadness.*

The rational mode of knowing throughout these narratives dominates the healing space by relying exclusively on reason and facts, logic and data (Palmer, 1998/2007). My sister is presented with statistics, treatment recommendations, and a list of possible side effects to consider, which was complex information new to her and me. She did not rely only on health care professionals to provide information for treatment recommendations. She accessed other information using the Internet and a naturopath. Today, health and other information is more accessible and immediate. We are moving to a consumerist model of health care where patients can pick and choose what type of health care they would prefer and health care environments may be viewed as marketplaces rather than moral communities (Austin, 2011). I begin to consider this shift in health care through the reflection of these narratives. I begin to question if transmission of diabetes knowledge is the sole purpose of diabetes education. Or are there other purposes that can exist that can offer more than a marketplace of information?

### **Relational Knowing**

In this personal experience, I am feeling tension between the specialized medical method of knowing I have and my relational knowing where I am feeling my sister's anxiety, distrust, and confusion that are giving her doubt to start chemotherapy. I believe

chemotherapy is the best choice. But I feel her hesitation about the medical treatment recommendations.

I reread my sister's email and note how she felt little was done to individualize her situation. She felt unheard. She wanted her illness story heard. The illness story becomes "the common bond of suffering that joins bodies in their shared vulnerability" (Frank, 1995, p. xi) and "reaches across the abyss that opens up between the ill person and others" (Frank, 1995, p. xi). Expressing the illness narrative "provides comfort from the suffering in a way that differs from the biomedical way of expressing it" (Ahlberg & Gibson, 2003, p. 149). I begin to understand that being a diabetes educator is not solely to transmit information. In the healing space, a relationship between the educator and patient that allows the exchange of knowledge in a transactional manner may promote healing. Being present and hearing the patient's illness story is a relational knowing that I now consider.

### **Listen to Your Sister**

*"We can't do chemo today. Your white count is too low," informs the oncologist.*

*"What do you mean?" she asks. "Can't we just go ahead?"*

*"No. If I said yes to chemo today, you would be in the hospital with an infection.*

*You have to stop taking these supplements. When your liver is metabolizing all those supplements, the chemo doesn't have a chance to clear from the liver. There is a traffic jam going on in your liver and you must stop those supplements."*

*"When can I start the chemo?" she asks.*

*"Let's give you a week. I want you to start Nupogen, medication to increase your white count."*

*I see the disappointment on her face. I realize how you psych yourself for this treatment and then to be told no, wait. It is so disappointing. I understand her reasons for taking supplements and feel her shame when the oncologist is telling her not to take the supplements.*

*The oncologist gets up to leave and emphatically repeats her earlier recommendation. “Get off those supplements.”*

*She glances over to me as she is leaving the office and says, “Listen to your sister. She is the dietitian!”*

I felt an acknowledgement and transfer of authority when the oncologist instructed my sister to listen to me. In that passing of authority, I witnessed my sister's shame. I felt uneasy and embarrassed with this responsibility. There was little opportunity in this encounter to discuss her reasons for choosing to consume the supplements. I consider this experience when I am counseling patients who disagree with treatment suggestions. I want to hear their thoughts, feelings, and concerns about their illness.

In objectivism, subjectivity is feared not only because it contaminates things but because it creates relationships between those things and us – and relationships are contaminating as well. When a thing ceases to be an object and becomes a vital, interactive part of our lives . . . it might get a grip on us, biasing us toward it, thus threatening the purity of our knowledge once again. (Palmer, 1998/2007, p. 52)

I may disagree with the patient's choices for diabetes management. However, I have discovered that relational knowing may help me understand these patient choices and we may be able to work together to manage diabetes.

I move towards multiple ways of knowing, including relational knowing, to be part of my professional identity. Rereading Mary Oliver's (1986) promise to "*not be good, to not have to walk on your knees for a hundred miles through the desert, repenting*" assures me that that my professional self is not just about living up to a high standard of knowledge acquisition that I then transfer to the patient. The self-criticism lessens, and what enters is a gentle and kind acceptance of self (LeBaron, 2004) that allows me to offer more than knowledge transfer in the healing space. Hearing the patient's story and using relational knowing helps healing. This does not mean to reject knowledge acquisition for continual striving of excellence. But I now consider attentively listening to the patient's narrative as we work together to manage diabetes.

*You only have to let the soft animal of your body  
love what it loves. (Oliver, 1986, p. 14)*

### **Food in the Healing Space**

In this next section, I provide stories to demonstrate the transformation of my belief of how food and nutrition can contribute to healing. I begin by including a College of Dietitians learning goal that I submitted for the yearly quality assurance activity required in my dietetics profession that focuses on individual nutrients in the diabetes culture. I move to an understanding of how whole foods can be nurturing and I translate that belief to my professional world.

*Over the next year, I want to develop knowledge about the new dietary reference intakes for antioxidants Vitamin C, Vitamin E, Selenium and Carotenoids. When I complete this goal, I will have a good review of antioxidants and apply this knowledge when I provide nutrition counselling to a variety of clients.*

*(C. Lenover's College of Dietitians of Ontario Learning Goal)*



I follow with a narrative that focuses on an educational approach that emphasizes individual nutrients in diabetes.

### **Nutrition and Diabetes Class**

*Let's review the information from last class. We talked about carbohydrates and how they can affect your blood sugar. When looking at carbohydrates, a reasonable amount is 45–60 g at a meal and 15–30 g for a snack. Let's take a look at the pamphlet that shows the carbohydrate foods. Each of the foods listed gives you 15 g carbohydrate. So that means 3 to 4 choices per meal and 1 to 2 choices per snack. Today I would like to also talk about fibre and sodium, as they are important to consider for heart disease protection. Make sure you include 25–50 g fibre in your diet and restrict sodium to 2,300 mg or less in a day.*

These two artifacts from my professional world demonstrate language that promotes nutrition and disease management through an atomistic approach. “Achieving good health through diet has become a matter of acquiring expertise in the micro-constituents of foodstuffs” (Lupton, 2012, p. 41). In contrast, I examine personal narratives that involve food and express a language of nurturance.

### **Food as Nurturance**

*To: Marlene  
From: Cheryl  
Subject: Thinking of you*

*Hi.*

*I am sorry to hear how awful you are feeling. I hope your cold will pass soon.  
I'm glad to hear the chicken soup and granola I made helped.*

*I realize how bleak these days are but I know you will get through this. I have*

*faith that you will have better days ahead. I will talk to you soon.*

*Cheryl*

*To: Cheryl*

*From: Marlene*

*Re: Thinking of you*

*Hi. Thanks -- last night was tough. We'll talk today. I don't know what I'd do without you & Mom!*

*To: Family*

*From: Marlene*

*Subject: Update*

*Hi there*

*Had my first week of radiation. It was tougher than I thought because I can feel some side effects already -- redness, stiffness in my right arm, and some fatigue. They say you don't feel much, but I can feel sometimes when they're zapping me -- and psychologically it's hard as you know radiation, like chemo, is toxic. It's great to have the weekend off from it -- going in M-F is pretty grueling. Will likely feel more some come week 6!! The actual treatment doesn't take long -- and it's much easier to be doing this.*

*Did everyone hear about our thawed food last weekend? I came back from the farm to realize that the freezer had been unplugged -- and my five bags of shrimp were thawed (from a great sale!) as well as some chicken, beef, a pizza, lasagne, some perogies, etc etc. So Cheryl helped out & we made some fabulous dishes on Sunday (had a great Indian meal -- with 5 dishes to sample from!) Cheryl tells me that there's a shrimp sale on again this weekend, so I just might stock up again!*

*To: Cheryl  
From: Marlene  
Subject: thank you for the meal*

*Hi there*

*I don't think I ever properly thanked you for the meal the other day . . . Or told you that I've almost singlehandedly polished off that apple cake. So delicious! (It must have sour cream in it). Very yummy indeed.*

*I am still suffering through this cold and I think I screwed up on the acupuncturist . . . I think it's not until next week that he's back... so the numb chin continues.*

*I hope they let me take the chemo tomorrow as I expect white cell count to be a little low . . . We'll see.*

*Talk to you soon.*

As I review these emails, I realize that in my personal life, food often expresses nurturance. I express care and support through food as my sister copes with chemotherapy. We have social interactions and experience connection as we prepare meals together. Food is present in these narratives and used while coping with the suffering from illness, and food provides comfort in the healing space we have together.

*You only have to let the soft animal of your body love what it loves.* I feel Mary Oliver's (1986) permission to enjoy food. When I counsel patients with diabetes, I wonder how often I include the concept of whole foods. I review my College of Dietitians learning goal and the diabetes class story and I question if the language expressed in this goal is a focus on nutrients and not on food as a whole.

When you are ill, you have a form of disconnection—you are differentiated

(Egnew, 2009). By focusing on nutrients and approaches to remove items from diet, I reinforce the feeling of separation. In these narratives and turning to Oliver's (1986) poem, I feel connections through the experience of sharing food. "When people share food, they seem to bond at a fundamental level which affirms their common identity" (Lee, 2011, p. 17). When I use language of whole foods in the healing space, I may connect with the patients who are present for diabetes education.

I include another email that I sent to my family days after we received the news that my sister's cancer had spread and palliative care was now present.

*To: Family  
From: Cheryl  
Subject: Update*

*Hi everyone.*

*Another couple of rough days. Right now, she is tired and in pain and emotionally about the same. We saw the oncologist yesterday and chest X-ray results were clear. She didn't start chemo as they want to give her radiation to the back of her skull to help with the jaw and chin pain. So yesterday afternoon, she got the CT scan done on her skull. Hopefully, the results will be back early next week and she can get some radiation to help decrease some of the pain and discomfort. She started some new meds also and it may be affecting her energy levels. It is hard to tell.*

*Mom is down with her and has been sleeping overnight here. I have been trying to relocate the work office as the extra commotion from work makes it difficult for her to rest. So, I may be sending an email asking for help to move office furniture to a new location. It might happen next Saturday. I will let you know if help is needed. The other thing that we may need is food. I am assessing the situation and will get back to*

*you. Sometimes, butter tarts just help a little. Will keep in touch.*

*Cheryl*

“Sometimes butter tarts just help a little” is language that is filled with deep emotion. This was a form of connection with my family as we struggled with the devastating news that the cancer had spread. We have family memories of butter tarts served at many family gatherings. Through the language of food, I was connecting with my family and providing nurturance. There are strong emotional feelings relating food, family, and nurturance.

The origin of the word “nurture” is from the Latin word meaning “nourish” (Merriam-Webster’s Collegiate Dictionary, 2014). Food, through nurturance, can nourish connection. I reevaluate my language in my professional world and aim for a focus on whole foods rather than micronutrients. With this shift towards a food focus, I may connect and form relationships with my patients through the language of food.

*Tell me about despair, yours, and I will tell you mine (Oliver, 1986, p. 14).*

### **Empathy in the Healing Space**

In this final section, I discover what empathy is through embodied experiences of feeling illness and I understand how having empathy in the healing space contributes to a connection with the individual. I begin with a narrative discussing a method to empower patients.

### **Empowerment Presentation**

*I rush into my office to check the slides one more time before tonight’s presentation on empowerment. I want to make sure the handouts match the slides. Lots of*

*people are coming tonight—the pharmacists from the committee, some family doctors, the nurses from work. I quickly make sure the slides are in order.*

*“Right, check to make sure I can convince participants to understand empowerment.” “Conviction and confidence. Helping people change their behaviours to help with diabetes. Empowering individuals to make changes.”*

*I review the handout that we developed based on Anderson and Funnell’s (2005) work and I am proud of how it turned out. I notice the title, “Steps to Promote Behaviour Change” and go through each step, reading the script I will present tonight:*

- *Identify the problem*
- *Explore feelings*
- *Set goals*
- *Make a plan*
- *Evaluate the results*

*“So, go through every step using the handout. Explore feelings. Evoke emotional response by asking questions. That can help to explore feelings.”*

Empowerment is encouraged in the diabetes world to facilitate behaviour change. I am focusing on method in this narrative and working through a checklist to empower an individual to change behaviour. I was presenting a process to achieve an outcome and to change behaviours. However, I did not fully understand the experience of exploring the emotions, as I had not embodied the emotions patients might have when ill. The lived illness experience helps me feel the emotions.

## **Chemo Day**

*Today is chemo. It's 7:30 am. I arrive at her house to pick her up. We want to get to the hospital early to avoid the long line at the lab.*

*Today's a cold, gloomy day. Last night, a heavy snowfall arrived over the city. So we are trying to navigate the city streets that are not ploughed as we travel to the hospital.*

*"Let's park at the hospital today. I don't feel like walking in this snow," she suggests as we approach the parking garage. I reach for the parking ticket, familiar with the routine. Grab your ticket, keep it with you, and then pay before you leave. I note the automation of this procedure. No parking attendant. No human contact. And remember your credit card to pay the \$15 on the way out.*

*We leave the parking garage and begin the same routine we do every chemo day that happens every 3 weeks. Arrive at the lab. Show your health card and take a number. Wait for your number to be called. Wait. Get your blood work done. Wait for your blood work to be analyzed. Wait and worry. Show your health card as you check in at the oncologist's office. Wait to be called by the oncologist's nurse. Wait and worry. Arrive at the oncologist's examining room. Wait anxiously for the oncologist. Wait. Have the oncologist arrive with her team of residents and interns. Wait to hear if chemo will happen. If chemo happens, go to the chemo suite, show your health card, and take a number. Wait for your number to be called. Wait. Arrive at the chemo room. Wait for your nurse to mix the chemo cocktail. Wait. Have the nurse begin the chemo. Watch and wait as the chemo slowly drips into your arm.*

*I note the time on my watch. It's 12:30 p.m.*

*The nurse begins the setup for the chemo. The yellow solution drips slowly through the IV. “Would you like a blanket to keep you warm?” she asks. “This type of chemo can give you a chill.”*

*“Ok. That sounds like a good idea.”*

*We sit together and wait as the chemo slowly drips. As we are eating the lunch I packed, I realize most of today has been spent waiting. I watch others around us and see us perform the same rituals of waiting.*

*After the chemo is done, we head home. Mom greets us with Leek and Potato Soup. I look at the clock and discover it is 3:30 in the afternoon. I’m exhausted.*

This narrative oozes the feeling of fatigue, boredom, and anxiety from the treatment experience. I relive these feelings when I listen to patients express their illness stories, and I begin to feel empathy.

Empathy is “the ability to perceive the meanings and feelings of another person, and to communicate that feeling to the other” (Wiseman, 2007, p. E61). It is important to note the difference between sympathy and empathy. “*Sympathy* involves imagining how one would feel if one were experiencing what is happening to the other; whereas *empathy* is imagining what it is like to be that person, experiencing the situation as she or he does” (Wiseman, 2007, p. E62). Through my own experience of accompanying someone receiving tests, treatments, and education for breast cancer, I felt emotions such as anxiety, sadness, boredom, and worry about the future. Feeling these emotions, I experienced empathy and began to perceive and understand what it would be like for an individual to receive diabetes treatment and education.



## Be Sad With Me

*I hear the phone ring. “Now what,” I wonder. I cringe, knowing that when the phone rings, bad news follows.*

*“Cheryl, it’s for you.”*

*“Hello.”*

*I hear her soft voice say, “Hi”. Then silence. “I just got off the phone with the nurse. It’s in my liver.”*

*“What? How do they know it’s in your liver?” I question with a panic tone in my voice.*

*“I called and asked about the ultrasound results. They could see it in my liver.”*

*“I knew this would be the result,” she cries.*

*My mind is racing. This can’t be. This isn’t real. What can I do? I have to do something. I can feel her pain and deep sadness over the phone.*

*“What do you want me to do?” I ask rapidly. “Do you want me to come over?” I can feel my heart beat rapidly.*

*“Cheryl, I don’t want you to do anything. I just want you to listen to me and be sad with me.” I stand in the hallway, holding the phone, and I can feel my breath stop.*

This conversation became embodied. My breath stopped. “Be sad with me,” she whispered in the phone. There was no need to “do” anything. This was a transforming moment that I will remember and carry forward with my patients. Sometimes, the only “method” needed in my diabetes encounters is to feel what my patients are feeling in the healing space we have together. Palmer (1998/2007) encourages teachers in their

classrooms to listen to the voices and truths of their students. I move to a healing space that encourages attentive and empathic listening to the voice of my patients.

What does it mean to listen to a voice before it is spoken? It means making space for the other, being aware of the other, paying attention to the other, honoring the other. It means not rushing to fill our [other's] silences with fearful speech of our own and not trying to coerce them into saying things that we want to hear. It means entering empathetically into the [other's] world so that he or she perceives you as someone who has the promise of being able to hear another person's truth. (Palmer, 1998/2007, p. 47)

More than anything I do or say, what helps someone who is suffering is how and who I am in the healing space. *Tell me about despair, yours, and I will tell you mine* instructs me to attentively listen to my patients' suffering and to demonstrate my empathy and connection with them. How can I be aware of my despair and hear their despair? Is being present with them emotionally the first step?

### **The Pigtail**

*She struggled with what she could wear. The fluid on her stomach kept growing, and her choice of clothing became more difficult. Today, I plan to drive her to the appointment. So, when I arrive, I notice she is wearing a cute skirt with a black sweater. "That looks nice," I tell her.*

*We sit in the tiny office at the hospital. Waiting. Waiting to here what is the next plan. The fluid in her abdomen is getting more and more present. I can see the fatigue on her face. She closes her eyes while waiting. What can I do? My heart is pounding. What will the doctor say? Will she come and say, "There is nothing more I can do"? I know*

*she is going over all the details from the blood tests with the students, like reviewing a car manual to explain why the car is not working any more.*

*She arrives in the office, alone today. No entourage. That's strange. No residents, no nurses. Just her. She seems quiet today. But she is also ready to set another plan into place.*

*"You need a drain," she informs us and begins to discuss the fine details of the drain insertion. A pigtail, they call it. We will note the irony later—two farm girls learning about a pigtail.*

*"But I would prefer just taking out the fluid and not having the drain in me permanently. Then I can go swimming. Do things." With a drain, there would be no swimming. With a drain, a sign that this is real and her liver is really failing.*

*"She is third spacing," whispers the doctor to me. I know in my brain what she means, her liver is failing, but I want to deny it. Ignore it. The fluid will return, ascites was the official term used, and there are risks of infection every time you aspirate the fluid. I agree and begin to discuss with the doctor the reasons this is the better choice. I remain fixed on the conversation with the doctor. I need to know all the details and the reasons for this choice. To make sure I understand. I have to understand so I can help her.*

*I look over at my sister and her eyes are red from the quiet tears, and I notice the deep sadness expressed on her face. She looks isolated. I pause in my conversation about the mechanics of this procedure as I observe in her eyes her despair and loneliness. Somehow, it just didn't matter anymore about the details.*

The details of the drain needed to be communicated. Through this experience, however, I believe these details were secondary. This was an experience of how to be present in the moment. The focus on drain details seemed to be less important when I felt my sister's sadness and deep empathy for her.

### **Sam and Patty**

*When she enters the hospital the last time, we are met with care and compassion. Sam, the big burly nurse, took care of us as we waited for the private hospital room. I note to myself the contradiction of his big, strong physical appearance with his gentle, soft voice. When it was time to transfer her, he told the porter to take it easy. Watch the bumps. You could feel the care in his voice. There was hesitation when he watched us move away. Suddenly, he offers, "I'm coming with you," and helps us. "Watch the corners and be careful not to bump into the wall near the elevator." He monitors every movement as we approach the fifth floor of the hospital.*

*Patty, one of the nurses on the fifth floor, greets us and helps us settle into the private room. She gently explains what is happening and answers our questions. She prepares us for what is imminent with care and compassion.*

*The moment has come. We see our sister, wife, mother, and daughter slip away, and we know she no longer is here. My pain is overwhelming.*

*Patty enters the room after my sister has died knowing what has happened. She begins to weep. I feel her sadness. I know she has her work to do. But she stops. She knows a life has stopped. I know she is busy, with many other patients to care for. But she stands there sobbing for the loss of my sister. I observe her pain that is my pain.*

I witnessed Patty's empathy as she felt my pain. She was in the moment with us, and she was feeling our loss. I wondered if she experienced loss. I felt her being mindful of the immediate experience, and I felt a connection with compassionate presence. There were no standardized methods or pressures from the outside to determine how she performed her job as a nurse. She was not focused on the doing; rather, she was focused on the being. She displayed an authenticity in her reaction to my loss.

In Chapter Five, I provide further reflections on the difference between my personal and professional experiences and the transfer of personal qualities into my professional self to allow a transformation of my professional identity that is more authentic.

## CHAPTER FIVE: MY BEING AS A DIABETES EDUCATOR

*Meanwhile the world goes on.  
Meanwhile the sun and the clear pebbles of the rain  
are moving across the landscapes,  
over the prairies and the deep trees,  
the mountains and the rivers.  
Meanwhile the wild geese, high in the clean blue air,  
are heading home again. (Oliver, 1986, p. 14)*

The connections of “Wild Geese” to the generated stories and the reflections discussed in the previous chapter produced three themes. These themes are:

1. knowledge exchange in the healing space
2. food in the healing space and
3. empathy in the healing space.

In the knowledge exchange theme, I become aware that my dominant method of knowing before personal illness and loss was through diabetes clinical practice guidelines and a form of technical and instrumental knowledge (Habermas, 1971). I begin to explore relational knowing as another possibility by seeking out patients’ narratives of their illness experience.

In the food exchange theme, I question the atomistic approach to healthy eating focusing on nutrients and not whole foods. I become aware food is used in my personal narratives as a language of nurturance.

Finally, in the empathy theme, I learn to feel the emotions of illness and to express my understandings to individuals of how they may feel living with illness.

In these three themes, I discover a difference in my professional self and in my personal self and begin to sense uneasiness with these differences. This uneasiness leads me to realize the possibility of a transformation in my professional identity. I discover

attentive listening, connection, and the beginnings of mindfulness present in the personal stories, and I begin to integrate these qualities in my professional experiences.

In this chapter, I connect Trede's (2012) three concepts of professional identity: the conscious self, social relations, language and discourse to the three themes: knowledge exchange, food, and empathy that were created in the last chapter from the generated stories and the integration of poetry. I discover transformational learning using a holistic process, and I consider how this transformation affects my being in the patient empowerment process in the diabetes healing space.

Each theme begins with stories from my professional life. These narratives demonstrate a factual and methods-based approach to teaching and healing in the social encounter with my patients. I observe my professional self influenced by external expectations of professional value, demonstration of outcomes, efficiency, and "the doing", action-oriented behavior. I was conscious of demonstrating value by what I could produce in an encounter with an individual with diabetes. My narratives use language that is factually based, focusing on evidence-based medicine and clinical practice guidelines, individual nutrients, and standardized methods to empower individuals to change. The individualized and empathic social interaction and connection with the patient seemed to be secondary.

Interrogating my stories and connecting with poetry lead me to discover a difference between my professional and personal selves. Reviewing my personal stories and reading Oliver's (1986) "Wild Geese" makes my self more conscious by considering the addition of alternative methods of knowing, such as relational knowing, using whole foods, and feeling empathy for patients. The three themes of knowledge exchange, food,

and empathy begin to emerge as forms of language that promote connectedness with others. I see in my personal stories, an awareness of communication that has possibilities for presence and connection rather than distance and isolation. “Wild Geese” begins to make sense and I feel connected to the poem, gently hearing Oliver’s (1986) reassurance of presence and healing. I become aware that the qualities of presence and connection are less in my professional encounters with patients as rational facts, logic and standardized methods dominate in the healing space. I consider presence and connection important qualities to help facilitate patient empowerment in diabetes.

According to K. Taylor et al. (2000), learning is a process of differentiation and integration. I feel learning is emerging as I discover a difference in my personal and professional lives after my personal illness experience. By the process of reflection on my sister’s breast cancer journey, I begin to draw critical attention to the question of what it means to know and what kinds of knowledge are held to be of most value in the culture of health care. I question how I approach healthy eating education. I question my relationships with the patients I serve. I see myself now changed personally and relationally through this process of reflection. Cranton and Carusetta (2004, as cited in E. M. Taylor, 2007) found teachers who critically reflect on “self, other, relationships and context are more likely to be working towards being authentic” (p. 178). My actions and ideas are coming from my internal self and are not controlled by others.

The difference causes me to question how authentic I am in my work as a diabetes educator. Feeling and reflecting on the lived experience of illness and loss helped me question my professional existence in the healing space. Is this profession mine, or am I acting in a way that is expected from outside my self from a state of fear? “We do not



need to *be* our fears” (Palmer, 1998/2007, p. 58). Looking inward and becoming more conscious of my self, I communicate to my self and find a voice from within and “a state of grace where encounters with otherness will not threaten [me] but will enrich [my] work and [my] life” (Palmer, 1998/2007, p. 58).

This research has given me the opportunity to search for meaning after my loss and to explore and integrate this meaning into my professional self. Through the process, I have maintained my values of altruism and service. What has transformed is my desire to create a more humane environment to connect with patients. Through attentive listening, empathy, and genuineness, I can create a therapeutic alliance by developing a caring relationship with my patients (Anderson & Funnell, 2008) and help with patient empowerment. I can be my patients’ companion on the journey of illness and create a healing space that is open to experiencing their illness stories. Turning to “Wild Geese” (Oliver, 1986), we have the potential to feel joy, as signified by the sun and sadness, as symbolized by the pebbles of the rain together in our time together.

I have not abandoned my objectivist perspective. I value the scientific knowledge present in diabetes. The Diabetes Control and Complications Trial Research Group (1993) and the United Kingdom Prospective Diabetes Study Group (1998) conducted two landmark studies that demonstrate good blood glucose control, good blood pressure control, and good cholesterol control significantly reduce rates of diabetes complication such as blindness, kidney disease, and heart disease. I remain committed to educating my patients regarding the benefits of good diabetes management.

Understanding and communicating medical knowledge remains important to me, and I will continue to use this way of knowing in my health profession. But I am now

finding balance in the wisdom of the humanities, such as poetry where I can find knowledge of the human condition including my own existence (Leggo, 2005). I felt hopeful reading “Wild Geese,” with the reassuring language and the beautiful imagery to listen and understand my self, and I felt a promise for the future.

As a result of my personal transformation, I am consciously constructing new patterns of interpersonal relationships in the healing space I offer for the patients I serve in diabetes education. Epstein (1999) suggests that health care professionals can develop an empathic understanding from the therapeutic alliance formed with their patients that will “intentionally guide patients in rewriting their life narratives to affirm normalcy, establish acceptance, discover meaning, make new connections to the world, transcend suffering and experience healing” (p. 833). I am working towards developing a connection and a therapeutic alliance.

My effectiveness as a healer is determined by my openness, self-awareness, and willingness for presence. With this long search of inward turning for healing and meaning, I’m “*heading home again*” to a revitalized self where wholeness and authenticity in my personal and professional being have been transformed and hence are more in alignment with each other.

My capacity as a diabetes educator has been more fully realized through the condition of personal loss. Before my personal experience as caregiver, I learned from an objectivist worldview. Evidence-based medicine was at my core. My professional worth was defined by how I could interpret research studies and inform health consumers of the latest research. Discussing nutrients and using standardized methods that may include sympathetic responses were often part of my encounters with patients. After my personal

experience and the meaning given from poetry, story, and reflection, I have a renewed sense of self that is more authentic.

### **Application to Practice**

According to Palmer (1998/2007), “good teaching comes from identity, not technique” (p. 66). Therefore, if I allow my revised identity as a diabetes educator, one who values connection and therapeutic alliance to be present, then this “technique can help me express my identity more fully” (Palmer, 1998/2007, p. 66).

Throughout the three themes, I begin to question my authenticity with the patients I serve in diabetes. Completing tasks and remaining busy, the “doing” is often how I approached a diabetes education encounter (White, 2013). I have now moved towards becoming aware of my “being” in the diabetes healing space to offer a more authentic self for my diabetes patients.

My personal stories and Oliver’s (1986) “Wild Geese” revealed the importance of being aware of my self and others, “the being.” This is the first step to establish connection and therapeutic alliance. Mindfulness can help me in my “being” by having “the awareness that emerges through paying attention, on purpose, in the present moment, and non-judgmentally to the unfolding of the experience moment by moment” (Kabat-Zinn, 2003, p. 145). As I move forward in both my personal and professional lives, I hope that integrating mindfulness into my practice will help me develop better ways of knowing, attentive listening, presence, and empathy that are key in the healing encounter.

## CHAPTER SIX: MOVING FORWARD

*Whoever you are, no matter how lonely,  
the world offers itself to your imagination,  
calls to you like the wild geese, harsh and exciting  
over and over announcing your place  
in the family of things. (Oliver, 1996, p. 14)*

This research began with a search for meaning when grieving the loss of my sister. I wanted to make sense of her breast cancer experience, and I chose autoethnography as a research method to examine my self and the health culture and to determine if my professional identity as a diabetes educator and Registered Dietitian transformed after the lived experience of illness and loss.

Trede's (2012) concepts of professional identity helped me develop a framework for analysis. I considered my conscious self influenced by the social interactions with the "other" through language and social discourse. To make my self more conscious and possibly begin to understand new beliefs about my professional self, I chose to implement a holistic perspective for transformational learning as proposed by Cranton and Roy (2003). Story, poetry, and reflection that called upon my cognitive, affective, and spiritual components of my self were used. Oliver's (1986) poem "Wild Geese" gave me a connecting point for reflection of a personal loss experience to my professional identity transformation.

The autoethnographic process was difficult. Initially, I questioned the legitimacy of this research, and I was concerned about how this type of research may be perceived in my culture of health care. Writing the narratives, at times, was impossible, as the emotions that surfaced reliving my sister's illness were raw. Other times, writing became a method to release these emotions. Writing "forces an externalization of communication,

wrests discussion away from the merely affective and/or psychological domains and forces a kind of reconciliation with material-inherently perspective altering, socio-communicative activity” (Burke, 2006, p. 85). Ultimately, autoethnography, through poetry, story, and reflection, gave me deeper understandings of my self and possibly of the patients I counsel in diabetes education. It expanded my consciousness of the interactions I have with patients in the healing space that led me to a transformation of my professional identity.

Initially, I felt uncomfortable using poetry and writing stories to make sense of an experience. These were new approaches to learning. However, through the research process, I found deep meaning using these methods, and I plan to continue to read poetry and write stories for future self-reflections.

I continue to believe in the role of biomedicine for diabetes management. What has transformed is the addition of the relational way of knowing. “Transformation requires that an old way of seeing and doing is changed to a new way of seeing or doing” (Scott, 1997, p. 41). Through reflection, I have become more self-aware and understand the complexity of illness and my diabetes education cannot be reduced to focusing on only knowledge transmission and method.

Using transformative learning theory to understand learning about teaching, we find that in order to expand the habit of mind related to “being an educator” we might experience the following: increasing self-awareness through consciousness-raising activities, making our assumptions and beliefs about our practice explicit, engaging in critical reflections on those assumptions or more intuitively imagining alternatives engaging in dialogue with others, and developing an

informed theory of practice (or a better justified perspective on practice). When we achieve new growth in our personal development, we also spontaneously achieve increased self-awareness, which we bring into our professional development. (Cranton, 2006, p.182)

I feel renewed and inspired. I have gained a more comprehensive understanding of an illness experience. Through this reflective and meaning-making process, I have made my professional self more conscious and invigorated.

I return to Mary Oliver (1986) again. *The world offers itself to your imagination, calls to you like the wild geese, harsh and exciting, over and over announcing your place, in the family of things.* This phrase encourages me to live my life from a place of my truest self, an authentic self, by *announcing my place*. I see myself now changed personally and relationally through this process of reflection, which I transfer to my professional world. I value connection and relationships with my patients, a therapeutic alliance. Becoming more conscious of self and other in the diabetes healing space encourages me to be aware of my presence, and I consider mindfulness in medicine an area of interest that I will continue to pursue.

I move forward, *in the family of things*, in my family of diabetes care, becoming a more humanistic educator. The path of humanistic diabetes education leads to a healing space of support and connection in the relationships I have with others.

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